STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005971	A. BUILDING: _____ B. WING _____	04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHABILITATION HOSPITAL OF INDIANA INC	4141 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor: 33212 Facility Number: 005971 Type of Survey: State Licensure Off Site Joint Commission Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 4/11-12/2016 Date of ISDH off site review - 6/30/2016 Based on review of the 4/12/2016 JCAHO Accreditation Survey Report, it has been determined that Rehabilitation Hospital of Indianapolis, Inc. meets the requirements for Hospital Licensure in Indiana for 2016.	S 000		